Colorado Department of Health Care Policy and Financing 1570 Grant St., Denver, CO 80203-1818	**NUMBER:** HCPF 07-007
	CROSS REFERENCE: HCPF 06-037
DIVISION OR OFFICE: Medical Assistance Office	**DATE:** February 23, 2007
SUBJECT AREA: Medicare Part D	
SUBJECT: Clarification of Medicare Part D premium payments for Home and Community Based Services and Alternative Care Facility Clients **TYPE:** I - Information	**APPROVED BY:** Barbara B. Prehmus, M.P.H.

HCPF Agency Letters can be accessed online at:
www.chcpf.state.co.us >> County and Medical Assistance Site Correspondence >>Agency Letters

Purpose:

Agency Letter HCPF 06-037 titled, "Medicare Part D Premium Deductions for Long Term Care Clients" dated December 6, 2006 provided County Departments of Human/Social Services and Medicaid Assistance Sites with guidance on deducting nursing facility clients' Medicare Part D premium from their Medicaid patient payment on the AP-5615 Form. This agency letter further clarifies the Medicare Part D premium payment process for Home and Community Based Service clients and Alternative Care Facility Clients.

Background:

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) establishes a new Part D program for prescription drug coverage. Those people who have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) can join a Medicare prescription drug plan. For individuals who are only eligible for Medicare, enrollment into this federal program is voluntary. Individuals who are both Medicaid and Medicare eligible (dual eligible) are deemed eligible for the drug benefit and they will automatically be enrolled.

Procedure or Information:

Clients who are receiving Home and Community Based Services (HCBS) are allowed to retain their monthly income as long as it does not exceed 300% of the SSI income limit. Clients with Medicare Part D should use this income to pay for their Medicare Part D premium if they have one. HCBS clients who need to establish an income trust because their monthly income exceeds the 300% limit receive an amount equal to 300% of the SSI income limit as a monthly disbursement from the income trust. The client is responsible for paying their Medicare Part D premium from this disbursed income.

Clients who are residents in an Alternative Care Facility will always be responsible for the room and board rate. The 2007 room and board rate is $571. This rate will not be reduced by the Medicare Part D premium amount for which the client may be responsible. If a client is in the 300% category of aid their non-covered medical needs are an allowable deduction. This deduction will only reduce any additional payments to the Alternative Care Facility for which the client is responsible, and does not decrease the client's responsibility for paying the full room and board rate.

The Single Entry Point case manager is responsible for calculating costs. It is also the responsibility of the Single Entry Point case manager to discuss the patient's liability while he/she is a resident in the Alternative Care Facility. The Single Entry Point case manager will also assist the client so that an informed decision can be made about whether the client has sufficient income to pay the room and board rate, their Part D premium, and other living expenses as needed. An example of a Client Payment Form is attached for a better understanding of the Alternative Care Facility calculations.

Effective Date:

Immediately

Contact Persons:

Janeece Lawrence
Adult Medicaid Policy Specialist
303-866-5928
Janeece.lawrence@state.co.us

Brian Zolynas
Medicaid Eligibility Policy Supervisor
303-866-2814
Brian.zolynas@state.co.us

Attachment:

Client Payment for Home and Community Based Services

CLIENT PAYMENT FOR HOME AND COMMUNITY BASED SERVICES

300% ACF CLIENTS - Post Eligibility Treatment of Income

See Special Instructions for Spousal Protection Clients

Client Name: | County:
Client ID: | Case Manager:
CM Phone #:

Client's Gross Monthly Income (from all sources) This includes, but is not limited to: Social Security, Railroad Retirement Benefits, Veterans Assistance, Private Pension/Retirement Benefits, or other.	A	$	700.00
Subtract Client's Monthly Allowance Old Age Pension (OAP) amount plus income disregard. Client is responsible for making the ACF room and board payment out of this amount.	B	$	668.00
Subtotal		$	32.00
Subtract Maintenance Allowance for Other Family Member (See Section 8.486.61 B.2. and B.3.)	C		
Subtotal		$	32.00
Subtract Allowances for Client's Non-covered Medical Needs (See Section 8.486.61(4)) This includes, but is not limited to: Health Insurance Premiums, Non-covered Medical Bills, Non-covered Prescription Drugs, Non-covered Medical Supplies and Equipment, Eye, Ear & Dental, and other Medical or Remedial Care (Please specify the non-covered needs and their amount, if you need more room, please attach on another sheet)	D	$	90.00
Total Adjusted Monthly Income	E	$	(58.00)

Client Payment to ACF (Please use either 1. or 2. below, not both)

Line F ACF Monthly Service Amount $ 1,286.46 Line G Standard R&B Amount $ 571.00

If the total Adjusted Monthly Income from above is greater than or equal to the ACF Service amount then:

1. Client's payment for ACF Services (this equals the ACF service amount)	F		n/a
Clients payment for ACF Room and Board	G		n/a
Client's Total Payment to ACF Client keeps any remaining amount.	H		n/a

If the total Adjusted Monthly Income from above is less than ACF service amount then:

2. Client's Payment for ACF Services (this is the total adjusted monthly income)	E	$	-
Client's payment for ACF room and board	G	$	571.00
Client's Total Payment to the ACF	I	$	571.00
Line F $ 1,286.46 minus Line E $ (58.00)			
Monthly amount billable by ACF to fiscal agent for remaining ACF Services (ACF Service amount minus the client's payment for ACF Services)	J	$	1,344.46
Daily Medicaid payment for services	K	$	42.29

Client Payment Amount

Client's Gross Monthly Income (from Above) minus the	A	$	700.00
Client Monthly Payment to Alternative Care Facility		$	571.00
Amount of client's income remaining after ACF payment (excluding deductions in C & D)		$	129.00

I have reviewed the information included on this page and understand that the payments indicated here are due beginning _____ and the 1st of each following month I receive services. I agree to report immediately to my case manager changes of $50 or more in income, expenses, or household makeup which affect my payment amount.

Client's/Guardian's Signature & Date

Case Manager's Signature & Date

Resident Payment to Facility	$	571.00	a month
Provider Reimbursement	$	42.29	a day

Client has small amount of money